Capital City Gastroenterology, P.C. 4126 Carmichael Court Montgomery, AL 36106

Phone: (334)495-2600 Fax: (334)495-2604

Patient Information

Last Name		First Name			MI	
(circle one)	ate of Birth:				S M W D	
991/1	-	Eman:				
,	□ African American □ Declined		an/Alaskan Native Pacific Islander			
Ethnicity (check on	e): Not Hispanic of	or Latino Declin	ed □ Hispanic or L	atino Other	r	
Address						
City		State	Zip (+4) _			
Home Phone ()_		_ Cell ()		Work ()_		
Primary Physician_		Referring Physician				
Occupation	Employer					
Emergency Contact			Relationship			
Home Phone ()_		_ Cell ()		Work ()_		
Pharmacy (Name/	Address/Phone)	Insurance Inf	Cormation			
		insurance in	<u>ormation</u>			
Primary Insurance	Company					
Policy Number		Group Number				
Policy Holder Name	2	Relation to Patient				
(if other than patient) Policy Holder Emp	loyer	Policy Holder Birthday				
Policy Holder Socia	l Security Number_					
Secondary Insuran	ce Company					
Policy Number		Group Number				
	e	Relation to Patient				
(if other than patient) Policy Holder Emp	loyer	BirthdaySS#				

Please provide a copy of front and back of all insurance cards.

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Please complete and sign this form in all places

payment of charges or fees is my respo	enterology, P.C. to make claims to my assigned and onsibility. I accept the fee charged as a legal and fees (33.33%), attorney fees and/or court costs.	l lawful debt and agree to pay said			
Print Name	Signature	Date			
I hereby authorize the release of all me behalf in accordance with HIPAA rules	edical information to my insurance companies as s. (See HIPAA NPP advice)	is necessary to file claims on my			
Print Name	Signature	Date			
procedures, office visits and services particles of the services particles and that I may be charged a national services particles.	ments to Capital City Gastroenterology, P.C. for rovided to me by Capital City Gastroenterology, to-show/cancellation fee of \$100.00 if I fail to ke occdure, except in the case of a verifiable emerg	, P.C. sep a scheduled procedure, or if I			
Print Name	Signature	Date			
agents may contact me by telephone at numbers, which could result in charges	erviced or monies to be collected, that Capital C any telephone number associated with my accord to you. I also agree to be contacted via text medude using pre-recorded/artificial voice message	unt, including wireless telephone essage or email using email address			
Print Name	Signature	Date			
May your lab results or procedure/or	ffice visit information be given to anyone other	er than yourself? Yes No			
If yes, who whom?					
Name	Relationship	Relationship			
Name	Relationship				
May we leave your lab results or app	pointment information on your answering ma	chine? Yes No			
May we send appointment or genera	l information to your email address? Yes	No			
Please sign and date to authorize rele	ease of information as described above.				
Print Name	Signature	Date			